



QuitlineNC

FAX REFERRAL FORM

1-800-QUIT-NOW

Fax completed form to: **1-800-483-3114**

Date Fax Sent: __/__/__

Provider Information:

Hospital-Clinic
(Facility) Name: _____ County _____

In order to receive a Participant's Outcome Report, you must be a HIPAA-Covered Entity

- I am a HIPAA-Covered Entity? (Please check one) ☐ Yes ☐ No ☐ I Don't Know
- I would like to receive a status report regarding this referral ☐ Yes ☐ No

Fax: (____) ____ - ____ Person Referring: _____ Contact Phone: (____) ____ - ____

Participant Information:

Gender: ☐ Male ☐ Female

Pregnant? ☐ Yes ☐ No

Participant Name: _____ DOB: __/__/__

Address: _____ City: _____ Zip: _____

Best # to call: (____) ____ - ____ Type: ____ Home ____ Work ____ CELL

Back-up # to call: (____) ____ - ____ Type: ____ Home ____ Work ____ CELL

Language Preference (check one): ☐ English ☐ Spanish ☐ Other - ____

____ (Initial) I am ready to quit tobacco within 30 days and request QuitlineNC to contact me to help me with my quit plan.

____ (Initial) I **DO NOT** give permission to QuitlineNC to leave a message when contacting me.

Participant Signature: _____ **Date:** __/__/__

Check the BEST time for QuitlineNC to call you.

☐ 9am - 12pm ☐ 12pm - 3pm ☐ 3pm - 6pm ☐ 6pm - 9pm ☐ 9pm - 12am

NOTE: The QuitlineNC is open 7 days a week; but call attempts to participants are only made until midnight. Also, calls made over the weekend may be made at times other than during this 3-hour time frame.

© 2008 Free & Clear, Inc. All rights reserved

Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. **Do not review, disclose, copy, or distribute.**



DOUBLE YOUR CHANCES OF QUITTING FOR GOOD

